

Introduction

Heart disease is one of the most significant and persistent public health problems in the United States, causing a tremendous burden of premature mortality and disability. It is the leading cause of death for men of all racial and ethnic groups, and although about half of all heart disease deaths occur among men and half among women, over 70 percent of premature (i.e. before age 65 years) heart disease deaths occur among men. From the mid-1960s to the mid-1980s, Americans experienced significant declines in heart disease mortality. However, recent studies have shown that from the mid-1980s to the present, those declines have slowed considerably, and have even stopped for some population groups. In addition, there are recent findings, reported in several scientific studies, that numerous community-based public health programs to reduce heart disease risk factors and prevent onset of the disease have had only limited effectiveness. Both of these trends have created a renewed sense of urgency in the public health community to develop and implement better and more effective programs and policies to reduce the burden of heart disease on our society.

This publication reflects our conviction that one of the keys to reducing the burden of heart disease nationwide is to focus our attention on patterns of heart disease mortality in local areas.

Why is it critical to understand local geographic disparities in the burden of heart disease among men? We contend that health disparities among places reflect underlying inequalities in local social environments that make some communities more health-promoting than others. The social environment provides the context within which individuals are exposed to structural risk factors (e.g. lack of economic opportunity, poverty, and social isolation) that contribute to adoption of disadvantageous behaviors (e.g. cigarette smoking, physical inactivity, poor diet). Understanding the health-promoting characteristics of local communities, and the barriers to change, is a critical first step in designing effective programs and policies. In addition, identifying the places that bear the greatest burden of heart disease mortality will permit the targeting of appropriate resources for improving the local social environment and health outcomes in those communities. A challenge for public health workers is that ameliorating the social environment in local communities will require structural and institutional changes, improvements in community social relations, and reductions in inequalities within those communities.

In *Men and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality*, we have produced an extensive series of national and state maps that present local variation in heart dis-

ease death rates for all men, American Indian and Alaska Native men, Asian and Pacific Islander men, African American men, Hispanic men, and white men for the period 1991-1995. These maps highlight both substantial racial and ethnic disparities in heart disease and the marked geographic disparities in the burden of heart disease that exist within each race and ethnicity group. In addition, we have included national maps of local indicators of the social environment. These indicators include the geographic distribution of population by race and ethnicity, availability of local economic resources, and the availability of medical care resources.

An important strength of *Men and Heart Disease* is our examination of geographic disparities in heart disease mortality for American Indian and Alaska Native men, Asian and Pacific Islander men, and Hispanic men. Previous reports have focused predominantly on reporting data for blacks and whites. While there are important data quality limitations for racial and ethnic groups other than whites and blacks, we chose to present results for men of all race and ethnicity groups. We hope that these results will both highlight the need for improved death certificate and population data quality, and provide useful information to public health agencies and advocacy groups who are working to improve health outcomes in diverse populations.

The race and ethnicity categories used in this publication have been officially adopted by the federal Office of Management and Budget (see Appendix B). Under the federal data reporting scheme, Hispanic is considered a designation of ethnicity, not race. Therefore, data for Hispanic men were included within each of the four racial categories, and were also analyzed separately. We use the terms “black” and “African American” interchangeably throughout this publication; similarly, “Latino” and “Hispanic” are used interchangeably as well.

Two perspectives on geographic disparities in heart disease among men are presented in *Men and Heart Disease*: a national perspective and a state perspective. The national perspective allows the comparison of heart disease death rates for all localities in the United States, visible on national maps that present county death rates separately for each race and ethnicity group. In contrast, the state perspective allows the comparison of heart disease death rates for all localities within a single state. *Men and Heart Disease* includes over 200 state maps, with at least two maps (for all men and white men) and up to six maps presented for each state. The national and state perspectives provide complementary information useful for targeting resources to high risk communities.

